

Appendix H.—Baltimore City Professional Standards Review Organization

Background on PSROS

Professional Standards Review Organizations (PSROS) were mandated in 1972 (Public Law 92-603) to review the utilization and quality of Medicare, Medicaid, and Maternal and Child Health services. These private, nonprofit corporations were set up for peer review and cost containment purposes. To achieve their goals, PSROS are required to collect a standardized set of data on each hospitalized Medicaid and Medicare patient. These data include diagnoses, procedures, average lengths of stay (ALOS), and mortality rates. Profiles of physician and hospital delivery patterns can then be prepared.

PSROS are also required to conduct quality of care reviews termed medical care evaluation (MCE) studies. A specific diagnosis or procedure in one or more hospitals is compared with specific quality of care criteria (recommended volume of procedures or indications for surgery), and improvements are recommended. If, for example, the PSRO determines that hospitalization or surgery is unnecessary or ALOS excessively prolonged, sanctions can be brought to bear against the hospital. These may include not only complete reviews of admissions or lengths of stay, but also withholding of Medicare and Medicaid payment.

While PSROS are one of the few agencies that systematically collect quality of care information on hospitals and providers, public access to these data has been somewhat limited, particularly access to physician-specific information. Some of the reasons for restricting disclosure, according to PSROS, are to protect patient privacy and the physician-patient relationship and to prevent unadjusted analyses of raw data. The issue of disclosure of PSRO information to the public has been much debated. Ted Bogue, formerly of Ralph Nader's Public Citizen Health Research Group (HRG), disputed the problems of disclosure to the public and local and State health agencies (21):

... Contrary to the claims of doctors, patient privacy and the doctor-patient relationship would not in any way be **compromised by public access to physician-specific information, so long as patients could not be identified.**

There is some concern that PSRO data could mislead the public because comparisons among providers would be invalid. Provider profiles and MCES could be adjusted by the PSRO for variations in patient age and diagnostic mix as a normal part of review activities. In addition, both the PSRO and the doctor or hospital under review could given an opportunity to attach explanatory material to whatever is released.

In a 1977 law suit, HRG charged that the National Capital Medical Foundation (the Washington, D. C., PSRO) withheld public information on utilization and quality of medical services. HRG requested these data under the Freedom of Information Act since, it argued, PSROS serve as Federal agencies. A decision in favor of HRG was handed down by the District Court in 1978. In response, PSROS, the Department of Health and Human Services (DHHS), provider groups, and Congress became embroiled in plans to appeal the decision, design confidentiality regulations, and place a moratorium on the final order.

A 1-year delay was approved, followed in 1981 by a reversal in the lower court holding that PSROS are not Federal agencies as specified under the Freedom of Information Act. In the meantime, the Institute of Medicine (IOM) was commissioned by Congress and DHHS "to study the public policy issues raised by the controversy and recommend a course of action" (184).

IOM recommended that there be clear limits on access to physician-specific information and quality of care studies performed by PSROS, and the court's ruling was in line with this recommendation. On the other hand, IOM recommended that hospital-specific information be made available to the public. The IOM committee also called for PSROS to take more initiative in informing the public about the type and effectiveness of health care in their areas. They suggested that this information, written in a form usable to consumers, might be disseminated as an annual report, IOM summarized the committee's findings (184):

The public, including the press and health planning agencies, should be able to obtain: 1) utilization data about identified institutions in the form of both data tapes and profiles produced by PSROS, and consisting of data elements that PSROS are required to collect for patients whose care is reimbursed by the Federal Government; 2) coded practitioner data, but with some safeguards to limit the deductive identification of specific practitioners; and 3) unidentified quality review study information, including anonymous, displayed performance data about institutions or comparisons among them.

The issue of public disclosure of routinely collected PSRO data is closely related to consumer information and choice. Consumers can, with limited difficulty, obtain information on physician credentials and fees. However, little quality of care information is presently available to consumers. Bogue describes the types of quality information that would be useful to consumers (179):

What consumers need is objective, accurate, meaningful information on the "track record" of individual

doctors and hospitals. What kind of patients do they treat, how long do they hospitalize patients, and what is their complications or mortality rate as compared to other providers treating comparable patients? Such information is crucial to fully informed consumer choice. For example, one study showed that post-surgical mortality is more than twice as high in some hospitals as in others, even after statistically adjusting for differences in patient age, medical condition, and other characteristics. Surely, no information could be more critical to a patient considering surgery.

Baltimore City PSRO

The Baltimore City PSRO is one PSRO that prides itself on the fact that data about hospital and physician utilization, costs, and outcomes of care are not confidential. Beginning in 1972, the State Medical Society set up the Maryland Admissions Review Program (MARF) to review hospital utilization for Medicaid patients. As a result of MARF's efforts at reducing unnecessary hospital utilization, it was possible to expand the scope of Medicaid benefits and eligibility criteria to cover more low-income people.

In addition, MARF found that a great deal of excessive hospitalization was the result of elderly patients' awaiting placement in long-term care facilities. As a result of these findings, the Baltimore PSRO investigated placement and utilization in chronic disease hospitals and found between 7 and 50 percent inappropriate placement. "BC-PSRO'S [The Baltimore City PSRO'S] report clarified that the backup of patients in hospitals was caused not by a lack of chronic hospital beds, but rather by problems in placing patients in nursing homes" (5).

Continuing their efforts to improve care for the elderly and reduce unnecessary use of Chronic Disease Hospitals and Skilled and Intermediate Care Facilities, the Baltimore City PSRO received Federal authority in 1978 to add nursing homes to its review. With the assistance of the State, the Federal Government, the local HSA, and the nursing home industry, the PSRO instituted the following measures: changes in reimbursement, grants to facilities with "hard to care for" patients, and new definitions of levels of long-term care.

Not until 1974 was the Baltimore City PSRO actually established. Many of the functions and physicians involved with MARF also took part in the newly formed PSRO. The purpose of the Baltimore City PSRO was to (5):

... assure that health care paid for by the Federal or State Government is medically necessary and consistent with professionally recognized standards of care. It also seeks to encourage the use of less costly sites and modes of treatment where medically appropriate.

Standards for medical care are set by the American Medical Association (AMA) and specialty societies, and compared with patient records to determine medical necessity and appropriateness. Hospital and physician profiles are then developed retrospectively to monitor delivery patterns and quality of care.

Beginning in 1979, the Baltimore City PSRO developed the Maryland Hospital Utilization Reporting System. This system, with nonconfidential data from the PSRO and the Maryland Health Services Cost Review Commission (HSCRC), profiles patients, physicians, and hospitals on a semiannual basis. In 1980, it became operational with data from 1978-81.

For each patient, the HSCRC report contains the following information:

1. hospital number;
2. physician number;
3. medical record number (only when report is confidential);
4. principal diagnosis;
5. secondary diagnosis;
6. principal procedure (with or without operation);
7. operating physician (performing the principal procedure);
8. age of patient;
9. total charge (daily room charge + seven ancillary charges—operating room, drugs, X-ray services, lab services, supplies, therapy services, all other);
10. length of stay;
11. preoperation stay (difference in days between the date of admission and date of principal procedure);
12. admitting type (elective, emergency, urgent);
13. admission day;
14. discharge day;
15. patient disposition (home/self care, short-term general hospital, left against medical advice, to skilled nursing facility, died); and
16. payment source (Medicare, Medicaid, Blue Cross, other insurance company).

The utilization figures are then compared with the physicians' and State's average, to compare hospitals and physicians and to assess ALOS by diagnostic-related grouping (DRG).

Unlike other peer review groups and rate-setting commissions in other States, those in Maryland operate under State legislation that all cost and utilization information, other than that regarding patients, be nonconfidential. With the cooperation of the HSCRC, the PSRO, hospitals, and medical societies, it is possible to generate a wide range of quality information. Physician-specific data are collected on types of cases (by DRG); number of patients, and ALOS. From these

data, comparisons can be made with the area average. Mental Hygiene, and the local Health Systems Agency to calculate, for example, days above average. Hospitals (HSA) are working together to address this latter problem as well as to determine the causes for the utilization patterns of their staffs.

In addition to data on hospital and physician utilization, charge data are collected on each patient by DRG, by age, and by length of stay. These charge data pertain to Medicare, Medicaid, Blue Cross, and "other" patients, and are broken down according to charges for hospital days, operating room, drugs, X-ray, lab, supply, therapy, and other services. To accomplish these changes, it is useful to be able to accurately document a problem and provide comparable data as well as to monitor changes and function of reward hospitals accordingly.

The Baltimore City PSRO has worked closely with the HSCRC to improve the quality, efficiency, and competitive practices of health services in the Baltimore area. Both groups believe that by disclosing health care cost control. Employers like Bethlehem Steel, Baltimore Gas & Electric, and Maryland National Bank are working with the PSRO to examine hospitals' efficiency and average charges by payment

The Baltimore City PSRO (4) reports that physical review based on the HSCRC data base has resulted in major reductions in lengths of stay. Four hospitals that previously had the highest ALOSs accounted for the majority of the improvements. The reduction in ALOS came not only from Medicare and Medicaid patients but also from the patients of Blue Cross and other third-party payers. An estimated \$8 million was saved in the last 2 years as a result of these efforts.

Baltimore City hospitals have traditionally longer patient stays for similar illnesses than have the other hospitals within the State. Based on calculations for similar illnesses, local hospital lengths of stay in the first half of 1978 exceeded the State average by .70 days per admission or more than 128,000 days above average per year. By the first half of 1980, this difference had been reduced to .55 days per admission or more than 105,000 days of care per year.

The remaining 105,000 days above average in Baltimore City are partially the result of special care units (newborn intensive care, shock trauma, psychiatric, etc.) and back-up days in hospitals while Medicare and Medicaid recipients await admission to nursing homes. The PSRO, the Department of Health and

Several organizations use these nonconfidential data, in some cases as a basis for sanctions. For example, the Baltimore City PSRO, as part of its peer review system, regularly examines hospital performance using these data, often with involvement from Blue Cross. The local HSA uses the data to determine the need for construction and expansion and to judge certificate-of-need applicants. The Maryland HSCRC is able to set hospital rates based on patients seen and performance guidelines. State licensure and the Joint Commission on Hospital Accreditation provide additional impetus for improvements. The Baltimore City PSRO suggests that hospitals improve their performance because it is "observable by the public."